Baystate Wing Hospital

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE BACK PAGE

PATIENT INFORMATION

FULL NAME:_____

ADDRESS: _____

_____

BIRTHDATE:_____

PRIMARY PHONE #:_____

RELEASE INFORMATION TO:

Check if you want Baystate Wing Hospital to release the medical records for this patient to someone you specify below.

Check if you want Baystate Wing Hospital to receive this patient's medical records from another health care provider.

Check if you want Baystate Wing Griswold Behavioral Health Center to release this patient's behavioral health records to someone you specify below.

Name:_____ Telephone_____

Address:_____

A. How would you like to receive this information?

☐ Paper Record ☐ CD ☐ Email Email Address:_____

I understand that my health record may include general information related to my mental health, drug/alcohol abuse, sexually transmitted diseases, abortion, or other information I may consider sensitive. I understand that this authorization pertains to information obtained on or before the date this authorization was signed. I authorize the release of the following information for dates of service from: **B.**_____ through **C.**_____

D. INFORMATION TO BE RELEASED

Please check one

☐ Please provide a 5 year abstract of my records.
*Note you will be invoiced at the allowable MA Statute rate

☐ Please provide my entire medical record
*Note you will be invoiced at the allowable MA Statute rate

☐ Other – please be specific, include dates and MD's under comments-
*Note you will be invoiced at the allowable MA Statute rate

Comments

Copy Fee: *Pursuant to Chapter 135 of the Acts of 2003, "An Act Establishing Fees for Copying Medical Records", Mass Gen. L. ch. 11, 70, we reserve the right to charge a reasonable fee for the cost of producing and mailing copies.*

E. PROTECTED UNDER STATE LAW

(*box must be checked to have information released*)

☐ Abortion
☐ Alcohol/ Drug Abuse
☐ Domestic Violence
☐ Genetic Testing
☐ HIV/AIDS Results/ Treatment
☐ Psychiatric Health –including psychotherapy notes
☐ Sexual Assault Counseling
☐ Sexually Transmitted Diseases
☐ **Other (specify)**:_____

F. THE PURPOSE OF THE RELEASE OF THIS INFORMATION IS FOR:

☐ Appointment with Specialist
☐ Transferring Care to New Provider
☐ Attorney/ Legal Case
☐ Disability/ Insurance Application/ Claim
☐ Personal Use
☐ Pre-employment

OTHER (specify):_____

Patient Name:_____ MRN:_____ Date:_____ Pg 2 of 2

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I UNDERSTAND THAT:

- This authorization is voluntary. I do not have to sign to assure treatment unless the sole purpose of treatment is to provide information to a third party (example: employment physical).
- I may inspect or copy information as provided in the Joint Notice of Information Practices.
- There may be a fee for photocopying my health information.
- Any disclosure carries the potential for un-authorized re-disclosure. I release Baystate Wing Hospital and Griswold Behavioral Health Center from any legal liability that may arise from the disclosure or re-disclosure of this information.
- I have the right to revoke this authorization at any time by presenting a written request to Health Information Management at the address below. Revocation will not apply to information that has already been released in response to this authorization. Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked this authorization will expire on the following date, event or condition: **G.**_____. If I fail to specify an expiration date, event or condition, this authorization shall be valid for not more than ninety (90) days from the date of the signature below, except when Federal and/or State regulations specify otherwise. In such situations, the shorter time period shall apply.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF THE INFORMATION REQUESTED ABOVE.

_____	_____	_____
H. Signature of Patient/ Parent/ Legal Representative*	**I.** Date	**J.** Signer's Relationship to Patient
_____	_____	_____
K. Witness to Signature	**L**. Date	**M**. For Hospital Use Only – Identification (MA License or Other)

If signing as a legal representative, also provide appropriate paperwork to support status.

N. Baystate Wing Hospital
Health Information Management
40 Wright Street
Palmer, MA 01069
Tel: 413-284-5391 Fax: 413-284-5390

"A copy of completed authorization must be given to patient."

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